

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

PRIMARY PHYSICIAN (PMP)

SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)

Name	Name
Address	Address
Telephone # with Area Code _____ Fax # with Area Code _____ Email _____ Provider # _____ Signature _____	Telephone # with Area Code _____ Fax # with Area Code _____ Email _____ Provider # _____ Signature _____

TYPE OF REFERRAL

<input type="checkbox"/> Patient 1 st <input type="checkbox"/> EPSDT Screening Date _____ <input type="checkbox"/> Case Management/Care Coordination	<input type="checkbox"/> Lock-in <input type="checkbox"/> Patient 1 st /EPSDT Screening Date _____ <input type="checkbox"/> Other
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LENGTH OF REFERRAL

Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.

REFERRAL VALID FOR

<input type="checkbox"/> Evaluation Only <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral) <input type="checkbox"/> Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)	<input type="checkbox"/> Treatment Only <input type="checkbox"/> Hospital Care (Outpatient) <input type="checkbox"/> Performance of Interperiodic Screening (if necessary)
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Reason for Referral By Primary Physician (PMP)	Other Conditons/Diagnosis Identified by Primary Physician (PMP)

CONSULTANT INFORMATION

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to primary physician (PMP) by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone

Instructions for Completing The Alabama Medicaid Agency Referral Form (Form 362)

TODAY'S DATE: Date form completed
REFERRAL DATE: Date referral becomes effective
RECIPIENT INFORMATION: Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name
PRIMARY PHYSICIAN: Provide all PMP information. **Must be signed by Primary Physician (PMP) or designee**
SCREENING PROVIDER: Screening provider (if different from Primary Physician) must complete and sign if the referral is the result of an EPSDT screening

TYPE OF REFERRAL:

- ◆ *Patient 1st* - Referral to consultant for Patient 1st recipient only (See *Chapter 39 for Claim Filing Instructions).
- ◆ *EPSDT* - Referral resulting from an EPSDT screening of a child **not in** the Patient 1st program – indicate screening date ((See *Appendix A for Claim Filing Instructions).
- ◆ *Case Management/Care Coordination* - Referral for case management services through Patient 1st Care Coordinators (See *Chapter 39 for Claim Filing Instructions).
- ◆ *Lock-In* - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See *Chapter 3 -3.3.2 for Claim Filing Instructions).
- ◆ *Patient 1st/EPSDT* - Referral is a result of an EPSDT screening of a child that **is in** the Patient 1st program – indicate screening date (See *Appendix A for Claim Filing Instructions).
- ◆ *Other* - For recipients who are not in Patient 1st program.

*"The Alabama Medicaid Provider Manual" is available on the Alabama Medicaid website

LENGTH OF REFERRAL: Indicate the number of visits/length of time for which the referral is valid.

Note: Must be completed for the referral to be valid.

REFERRAL VALID FOR:

- ◆ *Evaluation Only* - Consultant will evaluate and provide findings to Primary Physician (PMP).
- ◆ *Evaluation and Treatment* - Consultant can evaluate and treat for diagnosis listed on the referral.
- ◆ *Referral By Consultant to Other Provider For Identified Condition (Cascading Referral)* – After evaluation, consultant may, using Primary Physician's (PMP) provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- ◆ *Referral By Consultant To Other Provider For Additional Conditions Diagnosed By Consultant (Cascading Referral)* – Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the Primary Physician (PMP).
- ◆ *Treatment Only* - Consultant will treat for diagnosis listed on referral.
- ◆ *Hospital Care (Outpatient)* - Consultant may provide care in an outpatient setting.
- ◆ *Performance of Interperiodic Screening (if necessary)* - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.

REASON FOR REFERRAL BY PRIMARY PHYSICIAN (PMP): Indicate the reason/condition the recipient is being referred.

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PRIMARY PHYSICIAN: Indicate any condition present at the time of initial exam by PMP.

CONSULTANT INFORMATION: Consultant's name, address and telephone number.

PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY: The Primary Physician (PMP) should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.